Submit a Professional Claim with Primary Insurance other than Medicare

Frequently Asked Questions (FAQs)

Last Updated 02/17/2011

Q: What is the electronic TPL?

A: It is referencing electronic adjustment reasons without having to submit backup. TPL stands for Third Party Liability.

Q: Can we have a link to the PowerPoint slides for this presentation?

A: Today's PowerPoint can be located at: http://www.dshs.wa.gov/pdf/provider/Webinar/SubmitProfessionalclaimwithPrimaryIns.pdf

Q: How are we supposed to bill on paper with a HCFA and a copy of the EOB? What is supposed to be written on the claim? There is no way I'm going to spend 20 minutes entering all this stuff online for a whopping payment of $2 from DSHS, if I am lucky...

A: I would review our Billing and Resource Guide at the following address: http://hrsa.dshs.wa.gov/Download/ProviderOne_Billing_and_Resource_Guide/ProviderOne_Billing_and_Resource_Guide.pdf This guide will walk you through the process of submitting the paper CMS-1500 claim form and will instruct you what to write on the claim if necessary.

Q: Other than the NTE segment in the ANSI x12 format, what is necessary to bill insurance crossover claims electronically?

A: Currently we only receive crossover claims from Medicare. Commercial secondary claims would need to be submitted with the EOB or transmitted as shown in this direct data entry webinar or through an electronic batch.

Q: How is HIPAA observed if the full EOB is submitted? Not all claims within the EOB have Medicaid as secondary.

A: The coordination of benefits will disregard all other patient information submitted on the EOB other than the information that is needed for the claim to be processed.

Q: Are we able to mail HCFAs with EOB and no cover sheet

A: We highly recommend switching to electronic claims. If you are mailing in a paper claim you do not need to send a cover sheet with the claim form and back-up. If you are sending in back-up without the claim, then you will need a DSHS cover sheet.

Q: WHAT IF THE PT HAS TWO COMMERCIAL COVERAGES BEFORE MDCD?
A: Unfortunately ProviderOne has the ability to only have one insurance sent in electronically. If you have more than one please include a comment on the direct data entry claim that the client has more than one private insurance. Add total paid by both insurance companies and list it under one.

Q: For the adjustment amounts we put in what amount? What about the deductible?
A: We do not process claims using the adjusted amount. If applied to deductible enter zero in the insurance paid field.

Q: Will P1 ever allow us to save a template complete with provider data
A: This enhancement will be available February 2011.

Q: How do we know which codes are HIPAA compliant?
A: Here is a link to the federal HIPAA compliant adjustment and reason codes: http://www.wpc-edi.com/content/view/711/401/

Q: What is the unit for?
A: The unit lets DSHS know how many of the procedures that you performed. Normally it will be one unit per procedure

Q: Will there be a similar webinar for Medicare primary claims?
A: Yes there is currently a webinar done for Medicare primary claims. It can be located at: http://www.dshs.wa.gov/provider/training.shtml

Q: What does TPL stand for?
A: Third Party Liability

Q: Since this still requires "hands on" by COB staff, could you give us an idea of how long for turnaround (i.e., before I go checking or contact somebody to ensure this is correct) and what the present backlog may be.
A: I am not sure on an exact timeline, but am aware that the coordination of benefits office does have many claims to process. We will look into trying to get an estimated time for you and get back with you.

Q: We all have access to the Medicaid/ProviderOne fee schedule -- is it still correct that if the primary pays MORE than the Medicaid fee schedule on a CPT code, that Medicaid will NOT pay any additional and that would also save on NOT submitting claims for which there would be no payment. Correct?
A: Correct. If the commercial insurance paid more than DSHS allowable we would prefer you not bill us.

Q: Has the electronic file (EL) been fixed? Originally we were using this & were consistently told that ProviderOne was NOT receiving them, even though the attachment screen on this end showed it. AND is there a way to confirm receipt of this on PO's end?
A: I believe if this was a problem that it has been corrected. Currently the coordination of benefits office has been receiving claims submitted this way. If you continue to have issues with this please contact the customer service office with examples of the claim numbers.

Q: Did he say P1 will only accept numbers for Adjustment reasons? I know a lot of Insurances that use just Letters?
A: You did hear him correctly. The ProviderOne Adjustment Reason code box will only accept numbers. If your adjustment reason on the EOB includes letters leave them off and make sure that the code is an equivalent to a HIPAA compliant adjustment reason code.

Q: Can we fax paper claims with EOBs to you? If yes, what fax number do we use?
A: Paper claims cannot be faxed in. Even if they were they would still be considered paper claims and go through the same process, again which is quite lengthy.

Q: So we can simply mail you a HCFA claim form and EOB copy without a cover sheet AND without submitting it online?
A: Yes that is correct; however the paper claims do take longer to process

Q: Would you please give me the link to the printed copy for this webinar?
A: The PowerPoint can be located at http://www.dshs.wa.gov/pdf/provider/Webinar/SubmitProfessionalclaimwithPrimaryIns.pdf

Q: What do you use for a claim # on the bar code cover sheet?
A: ProviderOne will generate a TCN claim number prior to you opening up the cover sheet to print. I would suggest writing this number down or doing a copy and paste to add onto the coversheet.

Q: Where did you get the ID# used on the bar code cover sheet?
A: This would be your NPI number for the billing pay to provider.

Q: On the cover sheet, one has an option at the first scan bar for NPI, ID etc. which do you prefer? I have put the ID but that shows twice on the coversheet then. Should I be using the NPI?
A: We want you to utilize the NPI number on the cover sheet as the ID.

Q: Is railroad Medicare billed the same as Medicare?
A: Treat it just like it is Medicare. Thanks!

Q: Will there be a webinar on billing modifiers thru DDE (59 mod)
A: At this time there is not but we will take this into consideration as an upcoming webinar.

Q: Are providers able to submit crossover claims (where Medicare was primary) via ANSI 837? We're following the 837 companion guide (pages 40-45, 52-53) and we're sending "Electronic TPL" in Loop 2300, NTE segment and getting denials when Medicare was primary.
A: I am going to let our HIPAA office handle this question as they know what loops and segments are required on the 837 transactions.

Q: Will you cover 837 requirements in this webinar?
A: This will be telling you how to submit electronic Direct Data Entry claims, not specific 837 batches.

Q: When I try to adjust claims I get to the attachment screen and it ok (no attachments) and 9 times out of 10 I get an ERROR, is this because of my computers cookies? Attachment screen I hit OK,

A: This could happen for a number of reasons. You could be getting errors because you have not completed all the required claim data. You could also get an error if you don't have your pop up blockers turned off or if you use the browsers back arrows instead of the navigation buttons in ProviderOne. It would help us if we could see a screen shot of the error. You can email us at ProviderRelations@dshs.wa.gov Thank you!

Q: The problem is when I email or leave a message about a problem, I do not hear back from them for a while sometimes even weeks.

A: If you are submitting the emails to the providerrelations@dshs.wa.gov you should not be waiting for an answer. If you are utilizing the "Contact Us" form this goes into a triage system and the most severe questions are answered first. Try emailing the provider relations office directly.

Q: Do you recommend DDE for submitting 2ndry or 837 batch transmissions?

A: Either way is fine

Q: Is there a printable version?

A: Today's PowerPoint can be located at: http://www.dshs.wa.gov/pdf/provider/Webinar/SubmitProfessionalclaimwithPrimaryIns.pdf

Q: Did I hear you state that if you don't send backup you would enter adjustment reason codes at the claim level?

A: Yes you heard correctly. This is how the claims are currently being processed

Q: Any idea when HRSA will be current with processing claims?

A: Claims are being processed as quickly as possible. If Multicare has any COB claims that are in process, they are being special handled by a single worker in our COB office weekly.

Q: Why is it when I submit my secondary electronic with TPL info it takes over 1 1/2 to process??

A: If you are talking about the processing delay, the coordination of benefits office where these claims are processed does currently have a backlog of claims they are working. The claims are worked in the date order that they are received.

Q: What are the differences between the two boxes (Adjustment Group Code and Adjustment Reason) on slide 19?

A: Adjustment group code is the prefix alpha characters used on the adjustment reason such as PR-Patient Responsibility. The Adjustment Reason is the numeric numbers following the group code alpha characters

Q On slide 34, it instructs us to answer yes if Medicare is primary. Do we do that even if the Medicare EOB doesn't show that it was a "crossover" claim?

A: Only answer this if Medicare allowed the service.

Q: How do we bill claims where Medicare is primary and they denied the claim?
A: Then it is just a regular claim and you would not answer "YES" but you will need to enter a comment that the Medicare Denial is being submitted.

Q: Similar to primary claims, can secondary claims be submitted under any one of our domains regardless of what the billing NPI is?
A: You are able to enter the claims under any domain, but the billing provider and pay to provider will be different. The pay to domain will be the NPI that the claim actually belongs to and the billing domain is the one the claim is being sent from.

Q: Is there still a list of TPL carrier codes online? And if so, is it up-to-date?
A: Yes and it is up to date.

Q: Can I get the link to the TPL carrier codes please?
A: This can be found on the COB webpage: http://hrsa.dshs.wa.gov/LTPR/Providers.html

Q: Is there any way to set up a template for repeat claims?
A: This is currently under construction with the hopes that it will be up and running in February. Once this system upgrade is complete we will be producing a Webinar about how to use it.

Q: Nothing was mentioned about selecting primary or secondary.
A: DSHS will always be the payer of last resort. I do not think that provider has to select this.

Q: I enterer claims where Med Adv is primary as MCA XO and it denied as other ins, I thought MCA Adv is considered Medicare
A: Medicare Advantage is considered a XO. If the claim is denying for other insurance more than likely the claim is being entered incorrectly. We did do a webinar on submitting Medicare XO claims. It can be located at http://www.dshs.wa.gov/provider/training.shtml

Q: "Adjustment group code" is a box highlighted in the submission process. What the heck is it?
A: Adjustment group code is the prefix alpha characters used on the adjustment reason such as PR-patient responsibility. The Adjustment Reason is the numeric numbers following the group code alpha characters

Q: What is adjustment group code?
A: I think Gary was most likely trying to say adjustment reason code which is the HIPAA compliant code the insurance company uses on their EOB.

Q: What are TPL and BU and XO?
A: TPL is Third party liability; BU is Backup; XO is used for Medicare Crossover Claims

Q: Are you going to offer this webinar again?
A: this webinar is currently recorded and located at:
http://www.dshs.wa.gov/provider/training.shtml

Q: What is the entity qualifier "2 non person entity" and is that the only option? How would I know which one to use if there's more to choose from?

A: This is the only option that is currently available, but doesn't affect the processing as long as the ID, ID Type, and adjudication date is entered.

Q: How big is the backlog in the COB office?

A: Currently it is approx 600000 claims and we are working to get that down.

Q: Is there a way to do the FQHC Medicare crossovers which do not have allowed amounts?

A: This webinar is specific to commercial primary claims not the Medicare XO claims. We did do a webinar specific to Medicare XO which can be viewed at: http://www.dshs.wa.gov/provider/training.shtml

Q: But what if Medicare doesn't make a payment? It's not a crossover claim, then, correct? Would any Medicare information need to be included, or only the secondary (private insurance) information?

A: If the service is covered by Medicare and they did not make a payment we still need to see the denial EOB. If it is not a Medicare covered service we would only need the EOB from the commercial insurance.

Q: The ProviderOne billing instructions say that only the "payer name" and "COB paid amount boxes need to be filled out when submitting the claim, but pop-up errors then request that "additional other subscriber info - payer responsibility sequence code" and "additional other payer info - ID and ID type" also be filled out for claims submission. Is this a glitch in the website?

A: Gary will be going over this process during the webinar today. There were some updates that occurred after the ProviderOne guides were published. These changes are in the process of being updated.

Q: When Medicare is primary and private insurance is secondary and Medicaid is third, if Medicare does not pay anything on the claim, does the EOMB need to be submitted with the Provider One claim, or do you only need the secondary EOB (which shows payment)?

A: If the claim is electronic you will be able to enter the Medicare information and primary insurance information online and will not need to submit the EOBs as backup. If you are submitting on paper we will need to have these EOBs as backup.

Q: Why aren't all required fields auto-expanded so that it's clear what is actually required information?

A: In most cases, if the expander box is closed the information is not required but could be optional depended on claim information or client eligibility. Some fields become required when you open the expander box. There is one case where the information will always be required, regardless if the expander box is open or closed and this is in the client information section. All claims submitted to DSHS require the client's last name, date of birth, and gender.

Q: Can we submit secondary claims when Medicare is primary via clearinghouse?

A: You should be able to but will need to follow the instruction in the companion guides.